

STATE OF MAINE

BOARD OF ALCOHOL AND DRUG COUNSELORS

APPLICATION FOR LICENSED ALCOHOL & DRUG COUNSELOR (LADC) EXAMINATION



Department of Professional and Financial Regulation

Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8689
TTY/HEARING IMPAIRED 1-888-577-6690
FAX: (207) 624-8637

Office located at: 122 Northern Avenue, Gardiner, Maine

Email: voni.eames@maine.gov

<p style="text-align: center;"><u>APPLICATION INSTRUCTIONS</u> FOR LICENSED ALCOHOL AND DRUG COUNSELOR EXAMINATION</p>
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1. Complete and sign the application;
2. Submit a copy of birth certificate, driver's license, or passport;
3. Submit evidence of high school education or its equivalent, (if applying with only high school education), or transcripts of associate, bachelor or master's degree;
4. Submit a copy of driving record from the Maine Department of Motor Vehicles (or appropriate agency if you are from another state);
5. Submit verification from every state in which you hold or have ever held any type of license or credential to practice alcohol and drug counseling (if applicable);
6. Submit verification of clinically supervised work experience:
6000 hours with high school education (only 2000 hours required if you hold a valid CADDC license); or 4000 hours with Associate or Bachelor's Degree; or 2000 hours with Master's Degree;
7. Submit fee of \$ 135.00 (\$25.00 non-refundable application fee, \$95.00 written examination fee, and \$15.00 criminal history record check fee) - Make checks payable to Treasurer, State of Maine. If paying by credit card, please submit the enclosed authorization form with your application.

NOTE: This is an abbreviated checklist and does not replace the requirements outlined in the Alcohol and Drug Counseling Laws and Rules. Please review them carefully for more detailed and clarifying information.

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration **requires** a criminal history records check as part of the application process for each application filed with this office.

Public Law Chapter 401, sec. W-1, amends Title 25 §1541, sub-§6 to allow the State Bureau of Identification to charge a fee to government organizations for services provided. As of October 1, 1999 all criminal background checks of individuals are subject to a fee as determined by the Commissioner of Public Safety, which shall be \$15.00 as of May 1, 2003.

The following is the written examination schedule for 2006:

License Category Examinations	Date of Exam	Deadline for application filing with the Board Office
All levels: CADC,LADC, and CCS	03/10/2006	01/25/2006
All levels	06/09/2006	04/27/2006
All levels	09/08/2006	07/27/2006
All levels	12/08/2006	11/03/2006
Schedule for 2007		
All levels	03/09/2007	01/26/2007
All levels	06/08/2007	04/27/2007
All levels	09/14/2007	07/27/2007
All levels	12/14/2007	10/26/2007

For study guides go to www.icrcaoda.org.

The Board of Alcohol and Drug Counselors requires that all supporting documents and fees be submitted with the filing of your application. Your application will be considered incomplete and will be returned if supporting documents and/or fee are omitted. Documents that have been modified or altered in any way will not be accepted.



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AND FINANCIAL REGULATION
BOARD OF ALCOHOL AND DRUG COUNSELORS
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

Direct Tel: (207) 624-8689 Receptionist: (207) 624-8603
FAX: (207) 624-8637 - TTY/ Hearing Impaired: 1-888-577-6690

JOHN ELIAS BALDACCI
GOVERNOR

Lic: _____

CN _____

43501446 \$ 25.00

43501447 \$95.00

43502619 \$ 15.00

ANNE L. HEAD
DIRECTOR

APPLICATION FOR LICENSED ALCOHOL & DRUG COUNSELOR BY EXAMINATION

Application Fee:	\$ 25.00
Written Examination Fee:	\$95.00
Criminal History Record Check Fee:	<u>\$ 15.00</u>
TOTAL FEE DUE:	<u>\$135.00</u>

In order to qualify for the LADC license you must have taken and passed BOTH the ICRC/AODA written exam and the Advanced ICRC/AODA written exam.

Have you taken and passed the ICRC/AODA written examination? ☐ YES ☐ NO If yes, date you took the exam. _____

Have you taken and passed the **ADVANCED** ICRC/AODA written examination? ☐ YES ☐ NO If yes, date you took the advanced exam. _____

Name:		
Any other names used:		
Contact Address:		
City:	State:	Zip Code:
County:		Telephone #:
Social Security #:		Date of Birth:

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

AFFIDAVIT/DISCIPLINARY RECORD

Been indicted, arrested or convicted of any criminal offense (including motor vehicle offenses, but not including minor traffic or parking violations)? ☐Yes ☐No

If yes, please describe below in detail the crime(s), list dates(s), and submit a copy of the court judgements(s) as well as a letter from you explaining the circumstances surrounding your conviction.

Have any state or territory of the U.S., province/territory of Canada, or any other jurisdiction EVER denied your application for any type of examination, professional license, certificate or registration, or taken any disciplinary action against the license issued to you in that jurisdiction (including, but not limited to, warning, reprimand, fine, suspension, revocation or restrictions in permitted practice, probation with or without monitoring)? ☐Yes ☐No

If yes, please list date(s), type of license, registration or certification and state where occurred on a separate sheet of paper.

Please provide a copy of your driving record from the Maine Division of Motor Vehicles (or appropriate agency if you are from another state).

I hereby certify that all of the information given herein is true and complete to the best of my knowledge and belief. I also authorize any necessary investigations and the release of personal information to the State Board of Alcohol and Drug Counselors and its agents.

I understand that the fee of \$25.00 submitted herewith represents the preliminary application fee, which is non-refundable.

I agree to hold the State Board of Alcohol and Drug Counselors and its Board members, officers, agents, staff, peer evaluators, and examiners free from any civil liability for damages or complaints by reason of any action that is within the scope and arising out of the performance of their duties which they, or any of them, may take in connection with this application, the attendant examination, the grades with respect to any examination, an/or the failure of the Board to issue me a certificate of licensure.

The Ethics Committee of the International Certification Reciprocity Consortium has established a Disciplinary Information System (DIS) data bank which will list the ICRC certified counselors who has been sanctioned by their boards for violation of ethical standards and document the sanctions taken (i.e., revocation, suspension, etc.) The purpose of the DIS is to protect the consumer of alcohol and drug abuse counseling services from those individuals who have been proven to have violated the ethical boundaries required of professionals in this field.

The name of a Licensed Alcohol and Drug Counselor (LADC) in the State of Maine may be reported to the ICRC's DIS if he/she is sanctioned by the Board for violations of ethical standards.

AFFIDAVIT/DISCIPLINARY RECORD

By submitting this application and supporting documents I understand that the Board of Alcohol and Drug Counselors will rely upon this information for issuance of my license and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

By signing this statement, I acknowledge that I have read, understand, and agree to uphold the counselor Code of Ethics as it appears in the Rules of the Board and that I have been notified that my name may be reported to the International Certification Reciprocity Consortium Disciplinary Information System (DIS) data bank if I am sanctioned by the Maine State Board of Alcohol and Drug Counselors for violating the professional ethical standards of that Board.

Date

Signature of Applicant

CLINICALLY SUPERVISED EXPERIENCE

Name of Applicant:		
Address:		
City:	State:	Zip Code:
Applicants Job Title:		Telephone #:
<p><i>The following section is to be completed by employer or supervisor only</i></p>		
Name of Agency:		
Dates of Employment:		
From: _____ To: _____		
From: _____ To: _____		
Number of hours of clinically supervised work experience:		
I, the employer or supervisor, of the above named applicant is certifying the information provided on this form is verifiable, factual and accurate.		
Signature: _____ Date: _____		

TO SUPERVISOR COMPLETING THIS FORM:

**THIS FORM IS TO BE RETURNED DIRECTLY TO THE APPLICANT NOT TO THE
BOARD OF ALCOHOL AND DRUG COUNSELORS**

VERIFICATION OF LICENSURE

To be completed by applicant prior to mailing to each state in which you now hold or have ever held a license to practice. Please print. (This form may be copied as necessary)

Name: _____

Address: _____

(state) (zip code) Date of Birth: _____

License #: _____ Date Issued: _____

I hereby authorize the Licensing Authority of the State of _____ to furnish to the Maine State Board of Alcohol and Drug Counselors the information requested below.

Applicant Signature: _____ Date: _____

To be completed by the State Licensing Board or Credentialing Agency verifying the above information. Please complete this section and return to the applicants address above:

LICENSING BOARD OR AGENCY: This is to certify that the above-named individual was issued License or License/Credential# _____ to practice as a _____ on:

(date issued) _____ (expiration date) _____

Basis of Licensure:

- ☐ Examination: Indicate the year examination taken and by what State Licensing Board or Credentialing Agency.
- ☐ Grandfathering: Provide documentation of licensure/credentialing requirements at time of initial issuance
- ☐ ICRC Written Examination: _____ ☐ CPM Oral: _____
- ☐ State Exam _____ ☐ CCS Written Examination: _____
- ☐ Other _____
- ☐ Endorsement from _____ (Indicate state)
- ☐ Waiver - Indicate on what basis: _____

Status of License: ☐ Active ☐ Inactive ☐ Lapsed ☐ Other: _____

Date license expires/d: _____

Disciplinary Action: Has this license ever been revoked, suspended, limited, surrendered, restricted, placed on probation, encumbered in any way? ☐ Yes ☐ No

If yes, please attach a copy of the decision.

Signature: _____

Title: _____

State: _____

Date: _____

(SEAL)



John Elias Baldacci
GOVERNOR

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AND FINANCIAL REGULATION
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04333-0035

Anne L. Head
DIRECTOR



AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: (applicant fees being paid for)		
Mailing Address: (applicant fees being paid for)		
City:	State:	Zip Code:
County:		Telephone:
Name of cardholder: (if other than applicant)		
Mailing Address: (if other than applicant)		
City:	State:	Zip Code :

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐

Visa

☐

MasterCard

Card number

Expiration date: ____/____/____ in the amount of: \$ ____

Signature: _____ Date: ____/____/____

PHONE: (207)624-8603
(Office Phone)



PRINTED ON RECYCLED PAPER

1-888-577-6690 (TTY/HEARING IMPAIRED)

FAX: (207)624-8637



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ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission

Name: _____

Address: _____

Telephone #: _____ Social Security Number: _____

Accommodations Requested for the _____ Examination.

Disability _____

Please check all that apply

- ☐ **Accessible Testing Site**
- ☐ **Separate Testing Site**
- ☐ **Braille**
- ☐ **Large Print**
- ☐ **Tape**
- ☐ **Reader as Accommodation for Visual Impairment**
- ☐ **Scribe/Amanuensis as Accommodation for Visual or Motor Impairment**
- ☐ **Reader as Accommodation for Learning Disability**
- ☐ **Scribe/Amanuensis as Accommodation for Learning**
- ☐ **Sign Language Interpreter**
- ☐ **Extended Time**
 - ☐ **Time-and-a-half**
 - ☐ **Double time**
 - ☐ **More than double time (specify) _____**
- ☐ **Use of Computer or Other Adaptive Equipment (specify)**

- ☐ **Other:**

Signed and dated: _____

DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since _____ in my capacity as a

(Test applicant)

(date)

(Professional title)

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, providing the following should accommodate him/her: (check all types)

☐

Taped test

☐

Large print test

☐

Reader

☐

Scribe/amanuensis

☐

Extended time

☐

Time-and-a-half

☐

Double time

☐

More that double time (please justify) _____

☐

Separate Testing Area

☐

Use of Computer or Other Adaptive Equipment (please specify) _____

☐

Other (please specify) _____

Signed: _____ Title: _____

Date: _____ License # (if applicable): _____